FACT SHEET

Critical Access Hospital Program

LEGISLATION ENACTED AS PART OF THE BALANCED BUDGET ACT (BBA) OF 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs (Flex Program), under which certain facilities participating in Medicare as hospitals may terminate their hospital status and become Critical Access Hospitals (CAH). CAHs, unlike facilities such as Medicare Dependent Hospitals or Sole Community Hospitals, represent a separate provider type that has its own Conditions of Participation as well as a separate payment method.

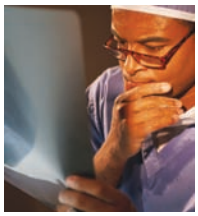
Critical Access Designation Hospital

A hospital must meet the following criteria to be designated a CAH:

- Be located in a state that has established a State Flex Program (as of August 2005, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have such a program);
- Be located in a rural area or be treated as rural under a special provision that allows hospitals in urban areas to be treated as rural for purposes of becoming a CAH;
- Provide 24-hour emergency care services, using either on-site or on-call staff;
- Provide no more than 25 inpatient beds;
- Have an average length of stay of 96 hours or less; and
- Be either more than 35 miles from a hospital or another CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR be certified by the State as of December 31, 2005 as being a "necessary provider" of health care services to residents in the area.

Critical Access Hospital Payments

Medicare pays CAHs for most inpatient and outpatient services to Medicare beneficiaries on the basis of 101 percent of their allowable and reasonable costs. Under the Medicare ambulance benefit, CAHs are also paid based on cost for ambulance services if they are the only ambulance supplier within 35 miles. CAHs are not subject to the Inpatient Hospital and Outpatient Prospective Payment Systems.



The Medicare Part A and Part B deductible and coinsurance rules applicable to hospitals also apply to CAHs. All outpatient CAH services other than pneumococcal pneumonia vaccines, influenza vaccines, administration of the vaccines, screening mammograms, and clinical diagnostic laboratory tests are subject to Medicare Part B deductible and coinsurance.

Reasonable Cost Payment Principles that Do NOT Apply to Critical Access Hospitals

Payment for inpatient or outpatient CAH services is NOT subject to the following reasonable cost principles:

- Lesser of cost charges; and
- Reasonable compensation equivalent limits.

In addition, payment to CAHs for inpatient CAH services is not subject to ceilings on hospital inpatient operating costs or the 1-day or 3-day preadmission payment window provisions.

Election of Standard Payment Method or Optional (Elective) Payment Method

Standard Payment Method—Cost-Based Facility Services, With Billing of Carrier for Professional Services

Under Section 1834(g) of the Social Security Act (the Act), CAHs are paid under the Standard Payment Method unless they elect to be paid under

the Optional (Elective) Payment Method. For cost reporting periods beginning on or after January 1, 2004, outpatient CAH services payments have been increased to the lesser of:

- 80 percent of the 101 percent of reasonable costs for outpatient CAH services OR
- 101 percent of the reasonable cost of the CAH in furnishing outpatient CAH services less the applicable Medicare Part B deductible and coinsurance amounts

Payment for professional medical services furnished in a CAH to CAH outpatients is made by the Medicare Carrier on a fee schedule, charge, or other fee basis, as applies if the services are furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner.

Optional (Elective) Payment Method—Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services (Method 2)

Under Section 1834(g) of the Act, a CAH may elect the Optional (Elective) Payment Method, under which it bills the Medicare Fiscal Intermediary (FI) for both facility services and professional services to its outpatients. However, even if a CAH makes this election, each practitioner furnishing professional services to CAH outpatients can choose whether to reassign billing rights to the CAH and look to the CAH for payment for the professional services or file claims for professional services through their Carrier. To reassign billing rights, individual practitioners must certify using Form CMS 855R, which states that the practitioner will not bill the Carrier for any services rendered at the CAH once the CAH has received the reassignment. CAHs must forward a copy of the completed form to their FI and the appropriate Carrier and keep the original on file. The CAH must have the practitioner sign an attestation that clearly states that the he or she will not bill the Carrier for any services rendered at the CAH once the reassignment has been given to the CAH. This attestation will remain at the CAH. If this method is chosen by the CAH, the election remains in effect for the entire cost reporting period and applies to all CAH services furnished in the CAH outpatient department during that period by physicians and other practitioners who have not elected to bill the Carrier for their professional services. This election must be renewed yearly based on the cost reporting year. Form CMS 855R can be found at **www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage** on the CMS website.

As of January 1, 2004, payment for outpatient CAH services under the Optional (Elective) Method is based on the sum of:

- The lesser of 80 percent of 101 percent of the reasonable cost of the CAH in furnishing CAH services OR 101 percent of the outpatient CAH services less applicable Medicare Part B deductible and coinsurance amounts AND
- 115 percent of the allowable amount, after applicable deductions, under the Medicare Physician Fee Schedule for physician professional services. Payment for nonphysician practitioner professional services is 115 percent of the amount that would otherwise be paid for the practitioner's professional services under the Medicare Physician Fee Schedule.

To elect the optional payment methodology or change a previous election, CAHs should notify their FI at least 30 days in advance of the affected cost reporting period.

Medicare Rural Pass-Through Funding Program for Anesthesia Services

CAHs may participate in the Medicare Rural Pass-Through Program to secure reasonable cost-based funding for certain anesthesia services as an incentive to continue to serve the Medicare population in rural areas. The ***Code of Federal Regulations*** under 42 CFR 412.113 lists the specific requirements a hospital must fulfill to receive rural pass-through funding from Medicare Part A for anesthesia services.

Health Professional Shortage Area Incentive Payments

If the CAH is located within a primary medical care Health Professional Shortage Area (HPSA), physicians who provide outpatient professional services in the

CAH are eligible for HPSA physician incentive payments. Payments to these CAHs for professional services of physicians in the outpatient department will be 115 percent multiplied by the amount under the Medicare Physician Fee Schedule multiplied by 110 percent.

Physician Scarcity Area Bonus Payments

Primary and specialty physicians affiliated with CAHs may also be eligible for a Physician Scarcity Area (PSA) bonus payment of five percent in areas that have few physicians available. One of the following modifiers must accompany the Healthcare Common Procedure Coding System code to indicate the type of physician:

- AG—Primary physician
- AF—Specialty physician

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Provisions that Impact Critical Access Hospitals

Under Section 405(b), for services furnished on or after January 1, 2005, cost-based reimbursement for costs of obtaining on-call coverage is extended to CAH costs of compensating physician assistants, nurse practitioners, and clinical nurse specialists who are on call to provide emergency services. Under previous law, this coverage was limited to compensation for emergency physicians who were on call to provide emergency services.

Section 405(c) states that periodic interim payments will be paid every two weeks for CAH inpatient services furnished on or after July 1, 2004 for CAHs that apply and qualify for the periodic interim payment method.

Section 405(d) mandates that for cost reporting periods beginning on and after July 1, 2004, each physician or other practitioner providing professional services in the hospital is not required to reassign his or her Medicare Part B benefits to the CAH in order for the CAH to select the Optional (Elective) Payment Method. For CAHs that elected the Optional (Elective) Payment Method before November 1, 2003 for a cost reporting period that began on or after July 1, 2001, the effective date of the rule is retroactive to July 1, 2001. For CAHs that elected the Optional (Elective) Payment Method on or after November 1, 2003, the effective date of the rule is July 1, 2004.

Under Section 405(e), beginning on January 1, 2004, CAHs may operate up to 25 beds for acute (hospital-level) inpatient care, subject to the 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or swing bed services. Prior to January 1, 2004, CAHs could not operate more than 15 acute care beds or more than 25 beds if it included up to ten swing beds.

Section 405(g) states that for cost reporting periods beginning on or after October 1, 2004, CAHs may establish psychiatric units and rehabilitation units that are distinct parts (DP) of the hospital. The total number of beds in each CAH DP may not exceed ten. These beds will not count against the CAH inpatient bed limit. Psychiatric and rehabilitation DPs must meet the applicable requirements for such beds in short-term general acute care hospitals, and Medicare payments will equal payments that would be made to general short-term acute care hospitals for these services (e.g., payments under the Inpatient Rehabilitation Prospective Payment System or the Inpatient Psychiatric Prospective Payment System). Payment for services in DP units of CAHs is not made on a reasonable costs basis.

Section 405(h) mandates that effective January 1, 2006, the provision permitting a state to waive the distance requirements for CAH status via State "necessary provider" designation will sunset. Providers with CAH status as "necessary providers" via State designation prior to January 1, 2006 will be grandfathered as CAHs on and after January 1, 2006.

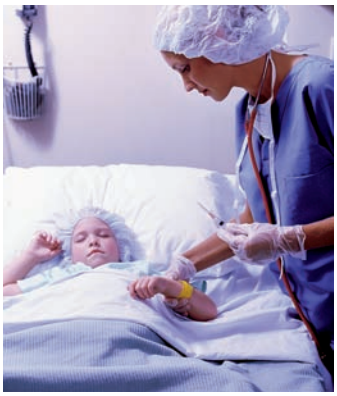
Grants to States Under the Medicare Rural Hospital Flexibility Program

The Flex Program, which was authorized by Section 4201 of the BBA, Public Law 105-33, consists of two separate but complementary components:

- A Medicare reimbursement program that provides approved cost-based reimbursement for certified CAHs administered by the Centers for Medicare & Medicaid Services; and
- A State grant program that supports the development of community-based rural organized systems of care in the participating states administered by the Health Resources and Services Administration through the Federal Office of Rural Health Policy.

To receive funds under the grant program, states must apply for the funds and engage in rural health planning through the development and maintenance of a State Rural Health Plan that:

- Designates and supports the conversions of CAHs;
- Promotes emergency medical services (EMS) integration initiatives by linking local EMS with CAHs and their network partners;
- Develops rural health networks to assist and support CAHs;
- Develops and supports quality improvement initiatives; and
- Evaluates their programs within the framework of national program goals.



HELPFUL RURAL HEALTH WEBSITES

CENTERS FOR MEDICARE & MEDICAID SERVICES' WEBSITES

CMS Contact Information Directory
www.cms.hhs.gov/apps/contacts/

CMS Forms
www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage

CMS Mailing Lists
www.cms.hhs.gov/apps/mailinglists/

Critical Access Hospital Provider Center
www.cms.hhs.gov/center/cah.asp

Federally Qualified Health Centers Provider Center
www.cms.hhs.gov/center/fqhc.asp

Hospital Provider Center
www.cms.hhs.gov/center/hospital.asp

HPSA/PSA (Physician Bonuses)
www.cms.hhs.gov/HPSAPSAPhysicianBonuses/

Internet-Only Manuals
www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage

MLN Matters Articles
www.cms.hhs.gov/MLNMattersArticles/

Medicare Learning Network
www.cms.hhs.gov/MLNGenInfo/

Medicare Modernization Update
www.cms.hhs.gov/MMAUpdate/

Physician's Resource Partner Center
www.cms.hhs.gov/center/physician.asp

Regulations & Guidance
www.cms.hhs.gov/home/regsguidance.asp

Rural Health Clinic Provider Center
www.cms.hhs.gov/center/rural.asp

OTHER ORGANIZATIONS' WEBSITES

Administration on Aging
www.aoa.gov

American Hospital Association Section for Small or Rural Hospitals
www.aha.org/aha/key_issues/rural/index.html

Health Resources and Services Administration
www.hrsa.gov

National Association of Community Health Centers
www.nachc.org

National Association of Rural Health Clinics
www.narhc.org

National Rural Health Association
www.nrharural.org

Rural Assistance Center
www.raconline.org

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